COLLEGE LECTURE

Safety and quality in healthcare: what can England and Australia learn from each other?

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ABSTRACT – Australia and England have similar healthcare systems. They are affordable and accessible to all; both are blessed with health professionals of great skill. Anybody who falls ill in either country can expect a high standard of care. And yet, all is not well. The care we give our patients is not as safe as it should be and the community is becoming well aware of this.[1,2] Our public healthcare systems never seem to have enough resources; our public hospitals show varying degrees of dilapidation. Access to care, while universal, is too often delayed. The medical workforce is understaffed, maldistributed (or both) and the shortage of nurses is of great concern. In both professions, morale is fragile. What, then, can be done to improve the safety and quality of healthcare in Australia and England?

The Australian healthcare system

Australia's health system stands somewhere between the market model of the US and the centralised command and control English model. Australia is a federation, with six states and two territories, each with its own government and health structure. Above all this there is the Commonwealth government.

The Australian health system provides universal access to healthcare services through a tax-based insurance system, Medicare (a different system to the US Medicare). There is, however, a mixed public and private system, with most primary and many specialist medical services provided by private practitioners. Private ambulatory services are directly financed by the Commonwealth government under the Medicare scheme. For inpatient hospital care, individuals can be treated in the public healthcare system. Alternatively, they can either take out health insurance with one of a group of organisations known colloquially as the 'private health funds' (British United Provident Association equivalents) or pay for private hospital care. At present, 45% of Australians carry private health insurance, so they have a choice to be treated privately. Moreover, most doctors have a private practice, so there is a safety valve for both doctors and patients if they encounter frustrations in the public system.

A comparison of the public hospital system in Australia and England

Australia

The public hospital system, which includes the academic medical centres and many smaller metropolitan and regional hospitals, is the responsibility of the states and territories. Funding for these hospitals comes in part from the Commonwealth government through substantial grants to the states and territories negotiated every few years, known as the 'healthcare agreements'. Commonwealth subsidies for prescribed medicines are another important aspect of the Medicare system.

The Commonwealth initially saw itself primarily as a funder of the health system, while the quality and outcomes of healthcare were a matter for the states. In more recent times, the Commonwealth has increasingly wanted to know about the outcomes of the care it was largely funding and to use its financial levers to ensure a focus on quality. However, in a complex, federal system it is not straightforward trying to engender a unified, co-ordinated approach to the quality and safety of care.

England

As an external observer of the health system in England, I see a national system that has been through a lot of change in recent years, initially through the introduction of the internal market, the creation of hospital trusts and local purchasing authorities. It then seemed to move back to a more co-operative model at the regional and local level, with nevertheless a strong centralised drive for further change. Resource levels have been heavily constrained for a long time; while there is now new investment, how is this money to flow through to patient care?

The English system is evidently more amenable to central command and control, despite the most recent shift in policy once again to decentralise and give greater responsibility and resources to the 28 new strategic health authorities and the primary care trusts. Operational control may move to the regions,

but major policy decisions remain in Whitehall. In Australia, with its nine governments and nine health systems, central command and control is not an option.

Quality of care

There are several aspects to care (Table 1). First among these is safety. Entering hospital carries the same risk as bungee jumping, but of course the total harm caused is much greater in hospitals because not many of us are committed bungee jumpers. In 1995, the Quality in Australian Health Care study[1] found that 16.6% of patients admitted to hospital were harmed, half of that harm being judged preventable. The amount of serious, preventable harm caused in Australia is similar to that in the US – and probably the UK – affecting perhaps 2–3% of patients admitted to hospital.

Australian Council for Safety and Quality in Health Care

After some years and much debate, the Australian Council for Safety and Quality in Health Care was established. In setting up the Council, which reports to all health ministers, I think the Commonwealth got several things right:

1. The health professionals represent a wide range of medical and nursing specialties. Thus, principle number one was observed: success comes if clinical leaders are involved.
2. States and territories have their own forum, the State Quality Officials Forum, which sits under the Council. This has given them a sense of ownership of the national enterprise. and has proved a real success.
3. Consumers are the people on the receiving end of our ministrations. They are often best placed to judge the quality of care. Their contribution to the work of the Council is proving invaluable.

Table 1. The aspects of care.

Care should be:
Safe
No harm occurs to the patient as a result of the healthcare provided
Effective
Bringing the patient to the best level of functioning by employing therapies that work
Giving the patient the care need when it is needed
Accessible
Not an issue for individual patients in the NHS, but it can be in the Australian system
Affordable
An important aspect that tends to be forgotten
Acceptable
Resources should not be wasted
Efficient

At a national level, and through state and territory governments, we have commitment and support ($50 million over five years – a lot in Australian terms) from our political leaders to improve patient safety and other aspects of the quality of care.

The national action plan

The most important principles of the current national action plan are the following:

- stop blaming individuals and put much greater effort into making systems of care safer and better
- acquire better data about adverse events and near misses
- ensure that the experience of patients is effectively harnessed to drive improvements
- promote greater community understanding of the difficulties of ensuring healthcare safety
- learn what works and what does not work in reducing errors or mitigating their effects, drawing from the experience of other industries and other countries
- establish a culture of safety.

Errors in healthcare

Hospitals are not high reliability organisations. There are three main reasons for this lack of reliability which reflect directly on doctors, and not on the complex and often less than supportive environment in which we work:

- lack of awareness of error
- acceptance of low levels of performance
- the fact that we, as professionals (authoritative, all-knowing, all-skilful), have great trouble dealing with error.

As few as 2% of errors in healthcare are caused by doctors' misconduct. The rest can reasonably be thought of as system errors. 'Every system is perfectly designed to produce the results that it gets' is an aphorism worth committing to memory. Safety has to be improved by design, not by command. But there is another, and more profound, element of our inability to deal with error in medicine, identified years ago by Neil McIntyre and the philosopher Karl Popper.[3] It arose from the belief that scientific knowledge is an absolute that:

> *can be acquired and stored in a person's mind. These ideas create an environment favourable to the emergence of authorities. To be an authority became an ideal of the old professionalism.*
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> *These ideas have terrible consequences. Authority tends to become important in its own right. An authority is not expected to err; if he does, his errors tend to be covered up to uphold the idea of authority. Thus, the old ethics lead to intellectual dishonesty. They lead us to hide our mistakes, and the consequences of this tendency may be worse even than those of the mistake that is being hidden.*

A logical extension of the thinking that harm to patients is all due to the individual doctor is to:

- concentrate on the training of doctors
- ensure that their skills are maintained by mandating involvement in professional development programmes, by annual appraisal and revalidation, and
- keep them under much more careful surveillance, so that the underperformer and the miscreant can be spotted before anybody is harmed.

While maintaining the highest possible standards amongst all health professionals is a laudable goal, of itself it is not enough. There is a growing understanding that the focus has to shift substantially from the performance of individuals to the environment in which they work. The solutions must be sought in improving the systems in which, and with which, doctors work – complex environments, with variously risky 'components'. Either the systems are made less complex (ie the components fewer) or the riskiest steps are made less risky – preferably both.

Improving safety

Changing cultures of work

It is worth noting what other industries have done. Commercial air travel is extraordinarily safe, certainly by comparison with the risks of hospital admission. The aviation industry has made two important changes which are instructive for the healthcare sector:

1. The hierarchical culture of the flight deck has been replaced by a culture of teamwork. The captain had absolute authority and his word could not be questioned – a culture which led to some major disasters. Now, the captain is *primus inter pares*.
2. Attention has also been paid to the design of systems, to include back-up and fail-safe systems to stop a pilot's mistake proceeding to catastrophe. Commercial airlines, with one or two notable exceptions, function as highly reliable '6 sigma' systems; we in healthcare, by contrast, function overall at 1–2 sigma.

Making medicine safer might be harder than improving safety in many other industries. The first difficulty is that as advances are made in safety, more problems will be uncovered, more loopholes, that previously had been tucked away out of sight. Where there has been a lack of awareness of harm – even a culture of denial or deliberate hiding of error – moving forward will bring into the open more evidence of harm. This is likely to generate fear, defensive reactions and an avowed scepticism about the data which hinders further improvement. This tendency will be exacerbated if the response from government is simply tougher regulation, more detailed scrutiny, tougher sanctions and penalties. The National Patient Safety Agency here in England will uncover new problems with its current pilot reporting system. How that information is managed when it is made public will be critical to the restoration and maintenance of public trust.

How to improve safety of healthcare?

The second major difficulty about improving the safety of healthcare is that we often do not quite know how to do it. Some necessary changes may be blindingly obvious: for example, altering fittings on anaesthetic machines so that the nitrous oxide and oxygen lines cannot be transposed. This sort of operational research will need significant resources.

The law of tort

The third difficulty is presented by the law of tort. Our desire to move beyond a blame-based approach to adverse events in healthcare comes up against the tort of negligence. The courts decide, in the circumstances of the case, whether a patient suffered harm due to a causally relevant breach of duty of care. If a court decides that there has been such a breach, the doctor (or nurse) may be liable for damages. It will not be easy to reconcile our attempts to foster a systems-based approach to patient safety with the present attitudes and practices of judges and juries.

Negligence and/or culpability

Most of us in the health arena tend to invest the term 'negligence' with an element of moral culpability, but the courts do not. A doctor might be found negligent, even though highly skilled and highly motivated, if it is found that, say, a momentary lapse or slip (of the sort that we all regularly make) meant that his or her standard of care on this occasion caused harm which was deemed foreseeable and did not measure up to what might reasonably be expected of someone of such skill and experience in the particular circumstances. For the court, it is not a moral issue. Since we feel morally culpable when deemed to be negligent, it is not surprising that open disclosure of error has been the exception rather than the rule, and that up to one-third of doctors who are sued become clinically depressed. The shame factor is potent.

What can be done to remedy this situation?

- We need to be able to acknowledge error, and better understand what is required to improve patient safety.
- We need to work with consumers to help resolve our difficulties with the law of tort. Open disclosure of error, with offer of support and fair compensation for the person harmed, will reverse the present unsustainable trends.
- We need to work through these issues with opinion leaders in the law. Judges seem mystified by talk of systems change and patient safety, and doctors do not fully understand the courts' approach to the tort of negligence.
- We may need government support for legislative change of various sorts.

My advice would be to keep a close eye on Australia, and see what we get right and what we get wrong.

What has been achieved in Australia?

The Australian Council for Safety and Quality in Health Care has been extraordinarily energetic, already producing some excellent policy documents and action plans. Initially, it operated at too high a level, and produced nothing that might save some lives or give patients better care. This has now changed, but it is a general problem for government or government-auspiced national bodies. How do they come down from high level policy to achieve co-ordinated, sustained change that makes a real difference?

One option for government is to regulate. It is seen to be responding, bringing about prompt change, and aligning policy and practical action as the political imperatives demand. But, as discussed earlier, doing this without moving to support the health professionals working in this complex and uncertain milieu, and without changing systems, may well change nothing – or indeed have perverse effects.

What initially moved most quickly in the work of the Council was related to clinical privileges and credentialling and, more controversially, the registration of doctors. This has now been put on hold for further discussion and consultation – a wise decision. A more thoughtful and considered approach is now being developed, with much wider consultation.

Much else, some of it front-line work, is going on under the aegis of the Council. For example, the Safety Innovations in Practice programme, and a major initiative on open disclosure of error involving the consumers. A third important initiative is the education programme, directed towards medical schools, postgraduate medical councils and colleges. Medical schools have had little to say about the safety and quality of care. Colleges (medical and nursing) have concentrated almost exclusively on developing the knowledge and technical skills of individuals. How best to apply those skills – safely, appropriately and effectively – has come a poor second. This will have to change, and the Education Steering Committee set up by the Council to bring about this change comprises deans, presidents, educationalists, managers and representatives from nursing and allied health. They have, in my view, a crucial role to play.

An outsider's view of the National Health Service in England

What about England? My information about the NHS comes from various sources, all impeccable but not necessarily comprehensive. My remarks may seem to lack balance, or even to verge on the gratuitous, but I hope an outsider's bird's-eye view of the NHS and its approach to improving the quality of health services will provide some food for thought.

If it is accepted that the NHS has been chronically under-resourced, that its infrastructure is creaking, its workforce inadequate, do the health professionals just throw up their hands and say what can those at the front line do in the face of all this? Of course not. My sense is that there are some extraordinarily effective initiatives within the NHS that are costing next to nothing, from which I hope we in Australia can learn.

The good side of the ledger

1. There are some excellent, high-level policy documents:
   - the NHS Plan
   - the national service frameworks
   - the policy work on information technology
   - *An organisation with a memory*,[4] a report concerned with patient safety – and many others.
2. This country has world leaders in the understanding of human error and what this means for patient safety.
3. As intimated earlier, there are some excellent initiatives in improving health services, some of which have been built from the ground up. Let me cite a couple of examples.
   - (i) *The Primary Care Collaborative*, based on the 'breakthrough collaborative' methodology developed by Don Berwick and his team at the Institute for Healthcare Improvement in Boston,[5] has been successful in improving access to care and the evidence base of the care patients receive. It now covers perhaps 20% of English general practices, and there is now a National Primary Care Development Team which has the ear of government, but which has not been slowed by what might be termed 'undue bureaucratisation'. I see this as an excellent example of how front-line activists and people in government responsible for policy can work together successfully to produce measurable improvement.
   - (ii) *The Cancer Services Collaborative* is another successful front-line project. Its aim has been: 'to improve the experiences and outcomes of care for people with suspected or diagnosed cancer by improving the way care is delivered'.

     Among the results of this initiative are major reductions in time to diagnosis (from months or weeks to days) in three separate hospitals for ovarian cancer, bowel cancer or prostate cancer. This had nothing to do with the skills or abilities of the staff concerned, but was achieved through service redesign by the people providing the service, including health professionals, supporting staff and managers.

Both these programmes, which have now moved from pilot to national in two years, are under the aegis of the Modernisation Agency. I hope the rest of the agency's work proves to be as effective. There are, of course, many other excellent initiatives, for example the work of Aidan Halligan's Clinical Governance Support Team in crafting an approach to improving the quality of care at the local level.

The less good side of the ledger

On the other side of the ledger, there seems to be an imbalance between, on the one hand, what might be called the regulatory measures, and on the other, the supportive, innovative and developmental work that will be needed. Much government

energy seems to have gone into the regulatory activities, with many new agencies which are seen to be adding further impositions on the health workforce: the National Institute for Clinical Excellence, the Commission for Health Improvement (CHI), the National Clinical Assessment Authority (NCAA), the new standards watchdog, the Council for the Regulation of Healthcare Professionals, annual appraisal, revalidation, etc. Each body may have a sound rationale, but they have come with a rush onto a somewhat dispirited and embattled workforce. Are they engendering the sort of changes to the system that health professionals will believe in and trust?

The dilemma was encapsulated in a *British Medical Journal* editorial in which the CHI was told that it needs to decide whether it is the quality police or a midwife of change.[6] My sense is that circumstances are requiring the CHI to be the former at the expense of the latter; if true, it is a matter for regret.

The emphasis on what I have called the 'regulatory activities' stems in part from the need for prompt action, but in part from a lack of understanding of how to reform what Amalberti has called a 'complex adaptive system', in which the emphasis should be more on the interaction between the elements of a system than on the elements themselves. The danger is that undue focus on the elements by relying on imposed, regulatory solutions will lead to no change – or indeed may have perverse effects.

It is interesting to note the responses in the USA to the publication of *To err is human* by the Institute of Medicine[7] which estimated that nearly 100,000 Americans are dying each year as a result of their healthcare. One response was to mandate the reporting of serious medical errors as a prerequisite for federal funding. This provoked an immediate riposte from the American Medical Association that this was a bad idea because it would put reporting doctors in jeopardy.

Doctors have been pitchforked out of their comfort zone ('the quality of our care is exemplary, no change is needed') into a zone of fear or anger ('learning and change over my dead body'). They should be in an intermediate zone, in which they accept that all is not as it should be, and where they know they will be supported to lead change, even when this might mean uncertainty, experiment and time. Are the NHS reforms positioning doctors in this intermediate zone?

The role of professional organisations

Finally, I want to reflect on the role that professional organisations such as the Royal College of Physicians (RCP) or the various specialist societies might play. If the safety and quality of care is to improve, clinical leadership will be a *sine qua non* – which means, in particular, the leadership of the medical profession.

My blueprint for the RCP or for, say, the British Society of Gastroenterology (the same is true for the equivalent bodies in Australia) is the following:

1. Colleges have to bring their members to a wider understanding of the safety and quality of care, the present problems and what might be done about them. The cerebral horsepower that the RCP and the Australasian College command is enormous – where then is the innovation to improve patient safety, the research ideas and the momentum to test those ideas?
2. Medical colleges and specialty groups have traditionally, and almost exclusively, focused on the knowledge and technical skills of the trainees in their basic and advanced training programmes. This must broaden: it is not just the acquisition of knowledge and skills, but how to apply them safely and to best effect in the uncertain and complex milieu in which these future specialists will have to work. This is the neglected issue.
3. There needs to be a more effective partnership with consumers. The relationship has to progress beyond 'them and us', particularly on issues relating to the safety and quality of care. We are in an era in which authority is passing from doctor to patient to a point where decisions about an individual's care are a shared responsibility. This is also happening on broader questions in health and health policy. It is a change that should be welcomed and assisted.
4. There is useful work to be done with leaders in the legal system. I would see this College, or perhaps the Academy of Medical Colleges, as able to exert considerable influence.
5. Lastly, there needs to be more intelligent and collaborative interaction with government, which does not mean always agreeing with, or being seen to agree with, government. My present job has taught me that government and health professionals are actually on the same side, both trying to achieve the best possible health and healthcare for the community. A major problem is the lack of understanding among both groups of the possibilities for action and the constraints that apply to the other group. There is too much mutual suspicion where there should be trust.

Perhaps the most important role for a body such as this College is to help convert sound, high-level policy into productive action on the ground. If we health professionals do not involve ourselves intelligently in this process, either nothing sensible will happen or something inappropriate will be instituted. Of course, too, this College should be exerting an influence on policy itself in a way which is not seen to be purely self-interested. The best way to ensure this is to work on policy issues in partnership with consumers. The Australasian College is learning this lesson, and some useful initiatives have resulted.

Conclusion

In conclusion, as I said at the beginning, both England and Australia provide a high standard of care to the community, but we can do better. There is an awareness in both countries of what needs to be done, and I am in no doubt that we have the skills and the will to do it.

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